Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **California** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Medi-Cal Waiver Program (MCWP)

C. Waiver Number:CA.0183
Original Base Waiver Number: CA.0183.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
11/12/23

Approved Effective Date of Waiver being Amended: 01/01/23

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to:

1. Include telehealth as a permanent service delivery option for specified waiver services, in compliance with California Welfare and Institutions Code section 14132.725; federal statute and regulations; and as agreed upon by the applicant, participant, legal representative, and Medi-Cal provider.
2. Update language for a state-level “Social Work Consultant” to assist with Program Compliance Reviews (PCRs) and record review to state-level “Program Advisor.”
3. Update language for state-level nurses from “Nurse Consultant” to “Registered Nurse”

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒	
☐	

Waiver Application	Additional Needed Information (Optional)
Appendix A Waiver Administration	A.6

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Kessel

First Name: Nichole

Title: Integrated Systems of Care, HCBS Policy Branch Chief

Agency: Department of Health Care Services

Address: 1501 Capitol Avenue

Address 2: P.O. Box 997413, MS 4502

City: Sacramento

State: **California**

Zip: 95899-7413

Phone: (916) 713-8345 **Ext:** ☐ **TTY**

Fax: (916) 552-9660

E-mail: Nichole.Kessel@dhcs.ca.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Halfman

First Name: Karl

Title: Chief, HIV Care Branch / Office of AIDS

Agency: California Department of Public Health

Address: MS 7700

Address 2: P.O. Box 997426

City: Sacramento

State: California

Zip: 95899-7426

Phone: (916) 449-5966 **Ext:** ☐ **TTY**

Fax: (916) 449-5959

E-mail: karl.halfman@cdph.ca.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: California

Zip:

Phone:

California Department of Public Health, Office of AIDS, HIV Care Branch, Special Programs Section.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

CDPH/OA is responsible for administering and monitoring the programmatic components of the MCWP. CDPH/OA reports results from monitoring activities to DHCS/HCDS/ISCD.

In accordance with 42 Code of Federal Regulations (CFR) 431.10, DHCS/HCDS/ISCD, as California's single State Medicaid Agency, delegates eligibility determinations to CDPH/OA. DHCS/HCDS/ISCD provides oversight to ensure that eligibility determinations comply with all Federal and State laws and relevant regulations and policies.

CDPH/OA maintains a formal system to monitor quality control, provider standards, participant centered care service plans, and services provided to participants to help ensure the health and welfare needs of individuals served under the MCWP are continuously met and safeguarded. The monitoring includes conducting onsite program compliance reviews (PCR), and review and evaluation of prior PCR summaries, review of provider quality assurance/quality improvement (QA/QI) plans, progress reports, paid claims data, and collection of federally-required fiscal audits. CDPH/OA reports monitoring results to DHCS/HCDS/ISCD.

PCR:
A CDPH/OA team, consisting of a Registered Nurse and Program Advisor, conducts a comprehensive PCR of each MCWP agency at least once every 24 months. A pre-determined portion of PCRs (frequency is determined annually by DHCS/HCDS/ISCD) are conducted in collaboration with a DHCS/HCDS/ISCD Nurse Evaluator II. The PCR consists of a contract monitoring component and participant record review component.

The contract monitoring component reviews and evaluates:
• Subcontracts and subcontractors' requirements;
• Caseload requirements;
• Provider licensure and qualification requirements;
• Written policies and procedures; and
• Fiscal requirements.

The participant record review component reviews and evaluates:
• MCWP eligibility including appropriate level of care assessments;
• Consent forms;
• Necessity and appropriateness of services;
• Timeliness and appropriateness of assessments, reassessments, PCSPs;
• Appropriate notice of action when applicable;
• Appropriate follow-up on participant grievances; and
• Appropriateness of payment for services delivered.

Provider QA/QI Review:
CDPH/OA requires MCWP agencies to implement a QA/QI program using CDPH/OA established guidelines to continually evaluate and improve the quality of services provided. MCWP agencies submit an annual QA/QI plan and a summary of QA/QI monitoring results to CDPH/OA semi-annually. MCWP agencies survey participants for satisfaction as part of their QA/QI activities and are required to submit summaries of the survey results to CDPH/OA for review. If CDPH/OA discovers problems or issues, CDPH/OA shall provide technical assistance to the MCWP agency. MCWP agencies shall include any issue or problem discovered by CDPH/OA for review on the subsequent QA/QI monitoring plan(s). CDPH/OA reviews these problems and/or issues during subsequent PCR, or as warranted.

Progress Reports Review:
MCWP agencies are required to submit progress reports bi-annually to CDPH/OA. The progress report provides monitoring information including: number of participants served by county, subcontractors, and types of contracted services, key staff and service providers' information (including licensure and/or certifications, and training), trends and barriers, participant grievances/requests for State Fair Hearings, risk assessment and mitigation, and technical assistance needs. CDPH/OA staff reviews and evaluates the progress reports and follows up with MCWP agencies to provide technical assistance and guidance as needed.

Fiscal Audits Review:
Annually, MCWP agencies are required to submit copies of fiscal audits as set forth in the United States Office of Management Budgets, 2 CFR Part 200 Uniform Guidance or in the California Health and Safety Code §§38040 – 38041 to CDPH/OA. Submission of these audits must be within the timeframes also set forth by these requirements. Per an

among qualified providers of the waiver services in the service plan.

To permit that participants have choice of providers, MCWP agencies are required to offer, when possible, at least three providers from each service category. During PCSP development, case managers provide participants with information on available providers, and discuss participants' preferences and choice of service providers. The MCWP participants acknowledge that they were given the above choices by signing the PCSP. Participants are continuously provided options of qualified providers and available service providers. On an ongoing basis, MCWP participants are encouraged to identify providers of waiver services who can best meet their medically necessary needs. Factors considered should include a provider's experience, abilities, and availability to provide services in a home and community-based setting, as well as the ability to work with the case management team, the participant's other caregivers, and the participant's current primary care physician. When requested by the participant and/or legal representative/legally responsible adults, the case management team can assist the participant and/or legal representative/legally responsible adults in identifying and accessing qualified waiver service providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

MCWP agencies use the PCSP form and PCSP Attachment A. CDPH/OA staff review and discuss the requirements with the Project Director during the 24-month Program Compliance Review and provides feedback and/or technical assistance as necessary. DHCS/HCDS/ISCD shall work collaboratively with and/or independently of CDPH/OA to ensure compliance with state and federal regulations, Medicaid statutes, the interagency agreement between DHCS and CDPH, and MCWP requirements ensure the PCSP is approved in accordance with 42 CFR §441.301 (b)(1)(i).

The state monitors PCSP development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of PCSPs. If errors in PCSPs are identified, the written report of the findings and recommendations that is issued to the site from CDPH/OA will include a formal written request for a CAP specific to remediating the errors. The site is required to respond to CDPH/OA and develop a formal plan to cover any deficiencies identified, which is then monitored by CDPH/OA.

DHCS/HCDS/ISCDs' review of CDPH/OA SOF reports and CAPs occurs on an ongoing basis. Additionally, the DHCS/HCDS/ISCD compliance team may accompany the CDPH/OA team during Program Compliance Reviews, as needed, to ensure all programmatic and Waiver requirements are being met. DHCS/HCDS/ISCD maintains authority to conduct independent on-site and or electronic visits to address deficiencies and to train/educate the MCWP agencies as appropriate. DHCS/HCDS/ISCD and CDPH/OA hold regular calls to discuss Program Compliance Reviews, including any PCSP related findings.

A CDPH/OA team, consisting of a Registered Nurse and Program Advisor, conducts a comprehensive PCR of each MCWP agency at least once every 24 months. The PCR consists of a contract monitoring component and participant record review component.
The participant record review component reviews and evaluates:

- MCWP eligibility including appropriate level of care assessments;
- Consent forms;
- Necessity and appropriateness of services;
- Timeliness and appropriateness of assessments, reassessments, PCSPs;
- Appropriate notice of action when applicable;
- Appropriate follow-up on participant grievances; and
- Appropriateness of payment for services delivered.

DHCS reviews the PCRs, site Corrective Action Plans and data reports, to ensure compliance with state and federal regulations, Medicaid statutes, the interagency agreement between CDPH and DHCS, and waiver requirements, on an ongoing flow basis. If DHCS' review identifies continued programmatic noncompliance, DHCS may recommend sanctions until the concerns are rectified. Depending on the findings, the sanctions can range from financial sanctions to discontinuation of the MCWP agency's contract to provide Waiver services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ◉ **Other schedule**

Specify the other schedule:

365 days or more frequently when necessary or upon participant's change of condition or service need

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

The formal chart review SOF Report is provided from CDPH/OA to the agency and DHCS/HCDS/ISCD within 30 days of each biennial PCR. Agencies are required to provide CAPs for all findings listed in the SOF and submit to CDPH/OA within 30 days of the receipt of the SOF report.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

When a MCWP agency is the only willing and qualified entity to provide direct care services in a geographical area, they may apply for an exemption to the conflict of interest standard. A MCWP agency must submit a written exemption request form outlining the services they wish to provide, who will provide these services, and the reason(s) services could not be secured by subcontract. CDPH/OA staff grants exemption on a case by case basis and services may not be provided prior to exemption approval. Exemptions are only allowable in cases where there is clear evidence that the MCWP agency has done due diligence in attempting to secure subcontractors for direct care services. Exemptions are granted for no more than one year at a time and will be rescinded if the MCWP agency is unable to maintain compliance with MCWP policies and procedures. An agency may receive an exemption to provide a direct care service, however those services may not be delivered by core MCWP staff including the Project Director, Nurse Case Manager and Social Work Case Manager. The MCWP agency Nurse Case Manager and Social Work Case Manager are responsible, in partnership with the participants, in assessment and service planning, therefore they are limited to case management provision and may not deliver direct care services. The Project Director is also prohibited from providing direct cares services.

In order to encourage that care planning and services are provided in the best interest of the participant, a MCWP agency that wishes to provide case management and other services must demonstrate that the participants' are informed of all alternative available resources in their area, utilize the standard level of care assessment for all participants, incorporate participant's preferences in the development of the individualized care plan, inform participants of their right to a grievance procedure, and conduct an annual participant satisfaction survey. Results of the participant satisfaction surveys are summarized and submitted to CDPH/OA staff annually.

Monitoring for compliance and conflict of interest is conducted by CDPH/OA staff during PCRs, bi-annual progress reports and participant satisfaction surveys reviews, and claims data as needed.

Agencies are required to demonstrate a good faith effort for obtaining qualified providers by documenting outreach efforts, including methods of solicitation and reasons why providers declined the solicitation offers. During PCRs, an OA health program advisor reviews the outreach efforts made by a MCWP agency to determine if good faith efforts were met and that the exemption request is appropriate. In addition, during PCRs a CDPH/OA Registered Nurse and Program Advisor reviews PCSP in the participant medical records to determine if the services listed in the PCSP are appropriate based on the medical needs of the participant. If the services rendered are irregular and/or above and beyond the level of care needed as documented in the PCSP then this constitutes a finding, and the agency is required to submit a CAP to remedy the finding. If the MCWP agency continues to be out of compliance after the CAP is submitted, then the matter is referred to DHCS Audits & Investigations for further review. If DHCS Audits & Investigations review identifies continued programmatic non-compliance, they may recommend sanctions until the concerns are rectified. Depending on the findings, the sanctions can range from financial sanctions to discontinuation of the MCWP agency's contract to provide Waiver services.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

annual Progress Reports. MCWP agencies are required to offer assistance to clients to navigate the written grievance process.
A State Fair Hearing is a formal grievance process, mandated by federal and state law. The request for a state hearing can be written or verbal and the client can represent themselves or have an attorney, neighbor, friend, etc. as representatives, all timelines are required by law. An Administrative Law Judge is the sole decider in the State Fair Hearing process.

The complaint and grievance processes are not prerequisites for a Request for a State Fair Hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*
If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

MCWP agencies are responsible for addressing the health and welfare needs of each MCWP participant on an on-going basis.

MCWP agency case managers are mandated reporters under California law (California Welfare and Institutions Code Section 15630(b)(1)). Case managers are required to report all incidents to the local Adult Protective Services (APS)/Child Protective Services (CPS) and law enforcement as indicated. Examples of reportable critical events or incidents include abuse (verbal, sexual, physical, or mental) or neglect; incidents posing an imminent danger to the MCWP participant, fraud or exploitation (including misuse of participant's funds and/or property), or an unsafe environment. The local county APS/CPS and/or law enforcement agency is responsible for investigating and resolving the reports.

For children, MCWP agencies must report the incident to CPS, local law enforcement, county probation departments, and county welfare departments as indicated. Reports are to be made by telephone immediately, or as soon as possible, and in writing within 36 hours of receiving information about the incident, alleged or otherwise.

For adults, MCWP agencies must report the incident to the appropriate APS and local law enforcement agency by telephone immediately, or as soon as possible, and in writing within two working days.

Incidents are identified and documented during the participant assessments, and PCSP process. MCWP agency case managers continuously monitor the progress and resolution. Ongoing monitoring of incidents, resolution strategies and outcomes are documented in the participant's assessments, progress notes and included on the PCSP.

MCWP agency will report any incidents to CDPH/OA on their biannual Progress Report including:
• Number of instances of abuse, neglect, exploitation or other critical event or incident reported for the reporting period;

• Types of abuse, neglect, exploitation, or other critical event or incident, i.e., physical, sexual, abandonment, isolation, abduction, financial, neglect, and self-neglect;
• Actions taken by MCWP staff (i.e., reports made to APS/CPS, local law enforcement, county probation department), etc. The report also identifies any teaching and/or support provided to the participant by MCWP staff; and
• Outcome and/or resolution of any reported incident indicating what could have been done to mitigate the incident before it occurred. The report also identifies actions taken by the MCWP case managers and participant in attempts to prevent/mitigate such incidents in the future.

CDPH/OA has a system in place to review reports on critical events and incidents and follow up with the MCWP agency to ensure participant health and welfare is protected. As part of the Progress Report review, CDPH/OA Nurse and Program staff review the description of the critical incident, the actions of the MCWP case management staff, and the outcome/resolution of any reported incident. CDPH/OA clinical staff will also review agencies documentation noting what could have been done to mitigate the incident before it occurred and what is being done now to prevent such incidents in the future.

Every MCWP agency shall develop, implement, and maintain its own policies and procedures for responding to incidents of abuse, neglect and exploitation. The policies and procedures required by CDPH/OA assure that there are operational procedures for managing incidents at the individual and provider level; that there are procedures in place to assure that incident reports are filed and investigated timely; that key staff are trained; and that incidents data is analyzed in order to develop strategies to reduce the risk and likelihood of the occurrence of incidents in the future and to improve the quality of services provided. These policies and procedures are in addition to what is in the law and shall include provisions from the Welfare and Institutions Code and the Penal Code.

CDPH/OA conducts follow-up and technical assistance is given during the routine Program Compliance Review at least every 24 months. Incident data is analyzed in order to develop strategies to reduce the risk and likelihood of the occurrence of instances in the future and to improve the quality of services provided.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The results of PCRs performed after CDPH/OA's remediation activities are analyzed in order to measure their effectiveness. This analysis may result in system changes to the PCRs and PCR tools and to methods of policy dissemination, technical assistance and training.

CDPH/OA analyzes and aggregates the findings from PCRs and ranks the findings according to significance. CDPH/OA staff develops strategies for training and technical assistance. CDPH/OA staff follow-up with MCWP agencies after the training is completed to measure efficacy of training.

CDPH/OA and DHCS/HCDS/ISCD discuss potential trends identified and implement additional technical assistance and remediation plans as warranted.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Every 12 months, preceding the submission of the CMS 372, DHCS and CDPH review the quality assurance system to assess whether the systems are identifying areas needed for quality improvement initiatives. By reviewing and updating performance metrics to assess whether changes are actually leading to improvement, DHCS and CDPH promote continuous quality improvement for the Waiver. System changes are identified and mutually agreed upon between DHCS and CDPH. The PCR tool is changed to reflect mutually agreed upon revisions.

Quality improvement input is also solicited from the MCWP agencies during the scheduled collaborative teleconferences between CDPH and MCWP agencies.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ◉ **No**
- ○ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

DHCS A&I, Financial Audits Branch shall ensure the fiscal integrity of the health programs administered by DHCS, its MCWP programs and affiliated Departments, to promote the quality of care provided to the beneficiaries of these programs through financial audits and in accordance with applicable laws, regulations, and program intent.

CDPH/OA makes referrals to DHCS/HCDS/ISCD, who in turn, forwards to DHCS Audits and Investigation requesting that audits of a particular MCWP agency be performed if there is a question about fiscal practices at the agency.

State Methods to Ensure Integrity of Provider Billings:
In order to claim reimbursement, an agency which chooses to be an organized health care delivery system in accordance with Appendix I-3, section (g)(2), must first obtain active status from DHCS Provider Enrollment Branch using the CDPH 8545, MCWP, Medi-Cal Provider Application. Federal regulations require Medicaid programs to ensure program integrity by requiring that providers disclose certain information. The Medi-Cal program attempts to deter potential fraud and abuse by requiring providers to complete the DHCS 6207, Medi-Cal Disclosure Statement form. The provider applicant declares under penalty of perjury under State laws that all information disclosed is true and accurate. The Medi-Cal Provider Enrollment Branch reviews all disclosures. If information disclosed is questionable and believed to result in fraud and/or abuse of Medi-Cal funds, follow-up is made and/or the application is denied. These application forms are submitted via CDPH/OA to the Payment Systems Division, DHCS for processing.

All providers of services to Medi-Cal beneficiaries must be enrolled as a Medi-Cal provider as required under state and federal Medicaid provider enrollment laws, including but not limited to:
- *42 U.S.C. 1396a(78),*
- *42 CFR Part 455, Subpart E,*
- *Welfare & Institutions Code, Division 1, Part 3, Chapter 7, Article 1.3,*
- *CCR, Title 22, Division 3, Subdivision 1, Article 1, and*
- *Applicable Medi-Cal Provider Enrollment Bulletins.*

MCWP agencies submit participant-related information including level of care (see Appendix B-6) to CDPH/OA. CDPH/OA confirms that participants are Medi-Cal eligible and not currently enrolled in the MCWP, then issues a participant specific MCWP identification number confirming their enrollment. All claims use MCWP specific procedure codes.

Medi-Cal pays MCWP agencies a flat monthly fee for case management services per eligible enrolled MCWP participant. All other MCWP services are reimbursed at cost, but not in excess of the rates established in the MCWP Program Rate Schedule.

Each MCWP agency is required by agreement to develop, implement, and maintain written fiscal policies and procedures that address:

• Tracking of services ordered, billed, and delivered;
• Tracking of costs of services for each participant to assure that the annual $33,937 maximum allowable reimbursement for each participant is not exceeded;
• Separation of duties for accounting staff responsible for accounts payable and receivable;
• Identification of expenditures by program, program components, and/or budgetary category; and
• The preparation and availability of financial statements for case management staff (for participant services portion) and the board of directors, or county board of supervisors, on a monthly basis.

Additionally, the following financial performance indicators are reviewed during the CDPH/OA Program Compliance Reviews conducted at least every 24 months at each MCWP agency:
• Licensing and certification of providers;
• Subcontracts with providers of direct care services;
• Direct care services ordered were actually delivered and accurately billed;
• Claims were submitted and paid in a timely manner;
• Only claims for Medi-Cal eligible participants enrolled in the MCWP were paid;
• Cost avoidance and resource evaluation are being overseen by qualified case managers and documented in the participant record;
• Vouchers/expenditures for nutritional supplements and transportation vouchers/expenditures are tracked separately by participant, date, and amount; and
• Qualified case manager staff-to-participant ratios meet CDPH/OA requirements; Full Time Equivalent (FTE) per program is documented and is accurate.

Prior to each biennial PCR, CDPH/OA staff requests the current and recently discharged list of participants sorted by case managers from the agency. In addition, CDPH/OA will request the agency billing from DHCS/HCDS/ISCD. A random representative sample of participant records for review is chosen. During the PCR, a CDPH/OA Registered Nurse and Program Advisor review participant billing records to determine: a) if the billed services are medically necessary and listed in the PCSP; and b) if the medically necessary services provided are billed.

CDPH/OA program advisors request the current and recently discharged list of participants sorted by case managers from the agency. CDPH/OA program advisors request the current and recently discharged list of participants sorted by case managers from the agency. CDPH/OA clinical staff select a random representative sample of a minimum of 10 records (if applicable) or 22.11% of the total records for review.

If a site contains more than one case management team, an equal number of records are selected to represent the work of each team or individual case manager. The sample is divided into three categories: a) participants newly enrolled during the review period, b) currently active participants and those enrolled prior to review period, and c) participants recently discharged for reasons other than death. Clinical staff will also review billing provided by DHCS/HCDS/ISCD to identify any heavy service utilizers and include them in the sample.

Program Compliance Reviews are conducted for each agency every 24 months. A team from CDPH/OA conducts the review. A Program Advisor and Registered Nurse perform the record review portion of the review, which includes reviewing the participant records. A program advisor conducts the contract monitoring review, which includes review of agency policies and procedures, subcontracts, and agency personnel files.

During each biennial program compliance review, CDPH/OA staff review the subcontracts to make sure that the payment rate matches the MCWP billing rate listed in the Medi-Cal Outpatient Services Manual. If the payment rate specified in the contract between the MCWP agency and the subcontractor differs from the rate in the Outpatient Services Manual, then a finding is issued in a SOF Report within 30 days and the agency must then submit a CAP to amend this finding within 30 days.

During Program Compliance Reviews, CDPH/OA staff reviews a sampling of MCWP agency and participant records to assure adequate documentation exists to validate provider billings and that billings were accurately made. Invalid or inaccurate claim submittals are automatically denied and the provider notified through a Remittance Advice Detail (RAD). Paid claims that are not valid or accurate, based on the MCWP agency agreement with CDPH/OA or an audit finding, may be recovered by the State and/or Federal Government.

The formal Contract Monitoring and Record Review SOF Reports are provided from CDPH/OA to the agency and DHCS/HCDS/ISCD within 30 days of each biennial Program Compliance Review. Agencies are required to provide CAPs for all findings listed in the SOFs and submit to CDPH/OA within 30 days of the receipt of the SOF reports. CDPH/OA provides feedback to CAPs and requests corrections if necessary, provides technical assistance and performs follow-up visits as needed.

MCWP agency bi-annual Progress Reports submitted to CDPH/OA include the following financial reporting:

• Existing, new, and terminated subcontractors by name, type of service provided, licenses and/or certifications (if applicable), and effective dates of the subcontract;
• Plans for replacing terminated subcontracts/services if necessary, to meet requirements; and
• Requests for technical assistance in billing, budget issues, and policy and procedure development; and
• All MCWP agencies are required to submit a Single Audit (annual independent audits of financial statements) and must comply with the Single Audit Act and the audit reporting requirements set forth in Uniform Guidance.

DHCS/HCDS/ISCD staff reviews paid claim data to monitor utilization of services. Reports are analyzed to determine the following:
• Lack or gaps in billing;
• Timeliness of paid claims;
• Correct utilization of rates and codes, as specified by waiver requirements;
• Tracking participant's costs compared to the Waiver services cap;
• Types and units of service billed; and
• Comparisons with statewide average billing per participant (total billed and by service).